R C
601
T5
Biology

UC-NRLF
B 3 116 381

C 88732

MENTAL DISORDERS

Briefly Described and Classified

WITH

A Few Remarks on Treatment and Prevention

By CHARLES B. THOMPSON, M. D.

Medical Director of the Mental Hygiene Society of Maryland

Assistant Dispensary Psychiatrist The Phipps Psychiatric Clinic, The Johns Hopkins Hospital

Baltimore

WARWICK & YORK, Inc.

1920

MARYLAND

CONTENTS

THE TWO TYPES OF MENTAL DISORDERS

A. Those associated with physical or chemical injury to brain tissue..... 5
B. Those which seem to exist only on psychological bases..... 5

A. MENTAL DISORDERS WITH DEFINITE INJURY TO BRAIN TISSUE

I. PHYSICAL INJURY—ORGANIC BRAIN DISEASE—Loss of Tissue. 5

1. General Paresis..... 5
2. Traumatic Disorders..... 8
   a. Delirium immediately following the accident..... 8
   b. Various degrees of loss of memory..... 8
   c. Conditions due to localized injury..... 8
   d. Post-traumatic constitution..... 8
   e. Terminal deterioration..... 8
3. Senile Psychosis..... 8
4. Arteriosclerotic Psychosis..... 9
5. Localized Injury..... 9
6. Diffuse Nervous Diseases..... 9
   a. Tuberculosis of the brain..... 9
   b. Tuberculous Meningitis..... 9
   c. Multiple Sclerosis..... 10
   d. Huntington's Chorea..... 10
7. Brain Tumor..... 10
8. Brain Syphilis..... 10
9. Brain Abscess..... 10
10. "Organic Brain Disease"..... 10
11. Idiocy and Feeble-Mindedness (congenital or due to injury at birth) 10
12. Constitutional Inferiority..... 11

II. CHEMICAL OR TOXIC INJURY—Injury by Poisoning..... 11

1. Alcoholic Psychoses..... 11
   a. Pathological Intoxication..... 11
   b. Delirium Tremens..... 12
   c. Acute Hallucinosis..... 12
   d. Alcoholic Constitution..... 12
   e. Alcoholic Paranoid States..... 12
   f. Korsakoff's Psychosis..... 13
2. Drug Psychoses..... 13
   a. Drug Habits..... 13
   b. Accidental Poisoning by Drugs..... 14
   c. Trade Poisoning by Drugs..... 14
   d. Illuminating Gas Poisoning..... 14
   e. Food Poisoning..... 14

3. Toxic-Infective-Exhaustive Reaction Type 15
a. Febrile (infection) 15
Delirium 15
Incidental Depressions in the course of certain diseases 15
b. Toxic-Exhaustive 16
Uremic, Diabetic, or Eclamptic Disorders 16
Thyroid Disturbances 16
c. Exhaustive—Extreme Lack of Sleep 16

COMBINED A. AND B. DISORDERS

1. Psychoses of Pregnancy 16
Treatment 17
Post Partum Psychoses 18
2. Epilepsy 18

B. DISORDERS EXPLICABLE IN PSYCHOLOGICAL TERMS

How Emotion Guides Behavior 20

I. THE MARKED MENTAL DISORDERS 22

1. Elation-Depression Oscillation (Manic-Depressive Psychosis) 22
2. Depressions Other than of Manic-Depressive Group 25
a. That caused by disease (more properly under Toxic) 25
b. Depression with hallucinations 26
c. Depression with paranoid trend 26
d. Agitated Depression 26
3. Atypical Excitements 26
4. Paranoia 27
5. Dementia Precox 28
a. Simple Type 29
b. Hebephrenic 30
c. Catatonic 31
d. Paranoid 32
Discussion of Development of Dementia Precox 34

II. THE NEUROSES OR "NERVOUSNESS", OF APPARENTLY WELL PEOPLE 41

1. Neurasthenia 42
2. Psychasthenia 42
3. Hysteria 42
4. Anxiety Neurosis 42
Discussion of Causes of Neuroses 43

PRINCIPLES OF TREATMENT OF MENTAL DISORDERS 44

PRINCIPLES OF PREVENTION OF MENTAL DISORDERS 47

List of Four References 48

503266

INTRODUCTION

This syllabus has been written in response to the growing desire for knowledge in Psychiatry. The method pursued has been, first, to describe the common disorders; second, to deduce therefrom a few essential principles as to causation and treatment.

It may perhaps be noted that the subject of child psychology, except in the discussion of Dementia Precox, has not been touched upon. Child psychology cannot be considered a thing apart from adult psychology. The two are continuous and identical, and we have but one, Human Psychology. The earlier phases of this are best studied through the Freudian literature and psycho-analysis. These show that the neuroses and many of the psychoses are distortions of this infantile mind coming into contact with the conditions and facts of everyday life.

I would suggest that this pamphlet be used as far as possible in conjunction with actual observation of cases, and in consultation with a trained psychiatrist.

All classifications, and especially this one, must be regarded as being more or less tentative, but while not final they enable us to utilize the definite facts which are already known. If this outline establishes a few landmarks and furthers a little the interest in its field it will have served its purpose.

Baltimore, Md.
April, 1920.

C. B. T.

MENTAL DISORDERS

Mental disorders fall into two general classes:

A. *Mental disorders in which there is definite injury to brain tissue.* Since the mind is dependent on the brain, there are mental changes as a consequence of the injury to the brain substance.

B. *Mental disorders which seem to be explicable entirely on a psychological basis.* These have been called emotional disturbances, "functional diseases," or emotional maladjustments.

The details of Class A. are given first. No mental disorder can be assumed to exist upon purely a psychological basis until the possibilities of physical illness have been eliminated by all the tests known to medicine.

A. MENTAL DISORDERS WITH DEFINITE INJURY TO BRAIN TISSUE

These are of two kinds according as the injury is

(1) *physical*, with absolute loss of brain tissue, forming the Organic Psychoses. The injury may have been caused by infection, hemorrhage, accident, arteriosclerosis, or some similar agent. These mental changes are permanent.

(2) *chemical* from poisons—called toxines—floating in the blood, hence acting on the brain tissue, and causing brain changes and mental symptoms, forming the Toxic Psychoses. The toxine may be an actual poison which has been taken into the body, such as an overdose of alcohol or opium, or it may arise from infection in the body, or be generated by a diseased organ within the body. These Psychoses may be permanent or only transitory.

I. Psychoses With Loss of Brain Tissue.

These have certain general characteristics, Memory Defect—there are absolute "holes in the memory" as if certain events or years had never happened; great Variation in Judgment—this is good one time, poor another; a very obvious Loss of Ability to Grasp Situations; sometimes attacks resembling epilepsy in appearance.

1. GENERAL PARESIS.

This is characterized by a deterioration of the mind and character due to a progressive damage to brain tissue, the cause being syphilis of the brain.

A formerly staid member of the community suddenly or gradually becomes careless in his appearance, in his behavior, and in his business habits.

There are gross lapses of memory, the most critical things are

jovially forgotten. Important business engagements are made and not kept, large deals are let go hang in the most haphazard fashion or other large deals are undertaken without judgment. His judgment is so impaired that he has delusions of grandeur, (grandiose ideas or Megalomania), everything is described by him in heroic style—he runs several hundred miles in a half hour; his friends and relatives are the monarchs of the various countries throughout the world; he is building a bridge to Europe; possesses millions and millions of dollars, etc. At the same time he shows tremendous gaps of memory, particularly of past events, leaving out periods of 10 or 15 years in giving a story of his life, and being unable to make any but the simplest calculations.

And the patient seems utterly oblivious to these as to all his other mistakes, in fact, he is highly pleased with his performance. His mood is generally that of euphoria or exaggerated self-complacency, the patient seeming to have no insight as to the pitifully small extent of his real capacities.

Further, there is a characteristic slurring speech with repetition of syllables, sometimes of words, such as "Third Artililerary Brigrgrade" or "Hypotapamus, hypotapamus, hypotapamus." There is often a great tremor of hands, and tremulous gait. Spinal fluid taken by lumbar puncture shows characteristic luetic changes (positive Wassermann, positive gold chloride test, high cell count). Blood Wassermann is often positive. In the later stages of the disease the patient deteriorates to such an extent that only the vegetative functions remain. He can but eat and sleep. There may be convulsions. Though as a rule the patient is unaware of his real condition, sometimes his insight is very clear and he is most distressed at watching his own mental disintegration.

The most dangerous point of the disease is that with this loss of memory and inefficiency, there are combined very exaggerated ideas of his own prowess and ability, so that the many complications which may arise when this disease comes upon a man in a responsible position, engaged in many important business dealings, may be tremendous. It is highly important to detect, if possible, an incipient case.

The *onset* is not always as sudden and as remarkable as given above; it may, on the contrary, be quite gradual and insidious. Many incipient cases of General Paresis have gone undiagnosed for a time, or have been considered to be mild excitement or depression. Diagnosis is important because of the *prognosis* which in General Paresis is always very gloomy, at least until further advances in the methods of medication have been worked out.

As *early symptoms* there may be merely change in disposition—a usually tidy person may become careless as to his general appearance;

occasional odd behavior—grossly inappropriate remarks may suddenly make their appearance; lapses of memory, or perhaps a sudden and transitory loss of consciousness may take place. The patient may become somewhat restless, or somewhat elated. A more careful test of memory, especially of retention, would show defects. There may often be a beginning speech defect in test phrases; there may be tremor of facial muscles or of the hands, or a beginning tremulous, uncertain gait. Lumbar puncture here is conclusive, the characteristics being a high cell count, strongly positive globulin test, positive Wassermann and gold chloride test.

GENERAL PARESIS

The patient was a young woman of 26 who had been arrested for shop-lifting, having just helped herself right and left wherever her fancy pleased. Moreover, she had placed orders in various other stores for five hundred shirts, dozens of pairs of stockings, etc. Her husband was a small Jewish tailor.

The woman appeared to be a young Jewish woman of about 28, who was quite euphoric and had a very lackadaisical manner. She talked very freely about herself, husband, etc. Said that she is an actress at the Hippodrome in the afternoons and evenings, also a waitress at Childs' in the mornings, and makes, with her husband, a great deal of money. Speaks of having paid $500 for a brooch, also $500 for a necklace, $300 for an automobile, etc., etc. Says that she has six children, and is supposed to have none. Says that her husband, who is a tailor, will make the doctor a suit of clothes for a Christmas present. She is also going to buy him a motorcycle with a sidecar, and he can take her out in it. She pulls out a blue silk handkerchief which she says her "gentleman friend," an Italian fellow, gave her. Tells the doctor she will give it to him and throws it on his desk. She talks of a dancing academy which she and her husband are going to establish on Greenmount Ave., and says that she bets the doctor will enjoy coming there. She spoke of having nine nieces, all of whom are going to marry well—doctors, engineers, etc.—and they are going to have nine weddings, all at the Emerson Hotel.

Her memory for dates is quite poor. Says she was married at 14, has been married 15 years, and is now 26. Does not see her error. Says her oldest child is 14, was born four years after marriage, there having been two still-births before that time.

ADVANCED CASE OF GENERAL PARESIS

The patient was a man of 48 who had been unable to work for a year. When first seen he was standing in his store dully trying to fasten his cuff, but being prevented by his great tremor. He had the typical greasy yellow complexion, and talked with scanning speech.

His first remark was, "I ain't sick." He had little memory for past events; did not know the name of the street in front of his store, and finally gave the name of one in another part of town. He gave his age as 42.

He frequently would wander out into the town, and be unable to find his way back.

Throughout the interview he kept repeating, "I ain't sick. I got hundred dollar Liberty Bond. I ain't sick. I got hundred dollar Liberty Bond."

2. TRAUMATIC DISORDERS (TRAUMA—INJURY), THOSE CAUSED BY ACCIDENTAL INJURY TO BRAIN.

These do not follow every accident by any means. As a rule they take place only when the accident has been so severe that the patient remains unconscious for hours or even days. Any one of the following may come separately, or it may appear combined with one of the other types:

a. Delirium immediately following the accident, i. e., loss of knowledge of the time and place—the patient has no idea as to the date or the situation, whether hospital or home, he may think it a ship, fort, workshop, etc. He may possibly have hallucinations.

The previous presence of alcoholism or senility may add coloring or duration to the picture.

b. Various degrees of loss of memory combined with apparently hysterical condition.

c. Conditions due to localized injury to one part of the brain, such as aphasia, with injury to speech mechanism, the patient may lose the ability to write or read; or asymbolia, wherein he loses all power of communication even by signs, etc. These may occur at once or they may appear later as residual conditions.

d. Post-traumatic constitution, easily affected by alcohol, grippe, fatigue, etc., with headaches or tendency to sudden and unwarranted outbursts of temper. Possibly with paranoid development (delusions of persecution or grandeur), or depression.

e. Conditions of deterioration coming considerably later from progressive changes in injured tissue, characterized by loss of memory, and loss of efficiency and of mental activity.

The patient before his accident was a telegraph lineman. He is aged 27.
He left school at the age of 13, in the 4th grade.
He had always been a hard worker.
On July 3, 1913, he fell 25 feet to the ground, landing on his left side. He was unconscious for 12 days. He remembers nothing until August, 1913.
Now he does not remember having climbed the pole, and remembers nothing concerning two to three days before the accident, (retrograde amnesia). He forgets events which occurred during the two weeks after he regained consciousness, (anterograde amnesia).
Since the accident there has been, according to the account of his relatives, a marked change in his efficiency and disposition. As seen in the hospital he cannot remember what he did during the just previous hour (going to town in a carriage); he has difficulty in recognizing people; difficulty in recognizing voices of friends over the telephone; his memory is impaired; he gets tired easily; he suffers from loss of confidence in himself; he has a violent temper and is easily irritated and restless; he considers his symptoms chiefly due to hospital life. Many references to end it all by suicide. Finally he left the hospital dissatisfied and irritated.

3. SENILE PSYCHOSIS.

This occurs, of course, generally in the aged, though there are some cases of premature senility as in cases of arteriosclerosis. The symptoms are forgetfulness, particularly of very recent events, con

trasted at times with a surprisingly clear memory of childhood events; a poor grasp of situations and indecision. Also the patient is particularly apt to get confused when called upon to transmit a message; or when he is obliged to act quickly and decisively, as, for instance, in crossing the street. If given abundance of time, however, he may get along satisfactorily. The patient is liable to sudden attacks of agitation or restlessness, especially at night when he may be overcome by a desire to get up and go somewhere, not knowing where or why, with afterwards entire forgetfulness of these attacks. Delirium may occur.

The patient is a laborer of 59. Whereas he had not worked for one year before the examination, he expressed himself as having been regularly in the employ of Swift & Co., and having worked the day before, or not longer than a week before. That he had injured his foot then in an accident (this had been months before). He stated that he received $15 a week, but to account for his not having any money in his pockets, he accused his daughter, at whose house he lived, of being in the habit of picking his pockets while he was asleep. He got rather excited over this.

He was mistaken as to the date, said it was early in January when it was February 3rd, but was oriented for place and person. He was liable to extreme outbursts of temper, getting extremely angry with his daughter over very small incidents. At night he would often get up and wander about the house: sometimes, he would turn on the gas without lighting it, apparently not realizing what he was doing, and go back to bed again leaving the gas turned on.

4. ARTERIOSCLEROTIC PSYCHOSIS.

As a rule, this occurs in men or women of advanced age, but it may occur in middle-aged or young people as a result of arteriosclerosis, and may cause premature senility. The symptoms, which may appear singly or in any sort of combination are a tendency to become easily irritated or moved to tears; loss of memory and a general dulling of acuteness; headache and ringing in the ears; signs of localized injury, such as aphasia; attacks of confusion with loss of sense of the time and place. At times there is a placid, contented or rather happy frame of mind. As an occasional, though striking, symptom, the patient will fall asleep at all other odd moments, often in the middle of a conversation. There are other signs of arteriosclerosis, tingling or numbness in the hands or feet.

5. VARIOUS STATES OF MIND DEPENDING ON LOCAL INJURIES WITH APHASIA, ASYMBOLIA, ETC.

6. DIFFUSE NERVOUS DISEASES.

a. Tuberculosis of brain.

This is marked by dullness, defect of judgment and memory, disorientation, stupor. Often a demonstrable tuberculous lesion elsewhere in the body as a primary focus from which the brain injury has developed.

b. Tuberculous meningitis.

The signs are excitement followed by lethargy with all the signs of meningitis, characteristic spinal fluid.

c. Multiple Sclerosis.

Symptoms are apathy, combined with deterioration.

The patient, a man of 38, had been a laborer, but had finally been prevented from working by his progressive paralysis which showed the typical signs of the disease. Becoming finally bedridden and nearly helpless, and showing some mental changes, he was brought to the hospital.

On the ward he showed great memory defect, and could give scarcely any dates of events in his life. He could place the date of his birth and marriage, but had forgotten the dates of any of the positions he had held. Because of this defective memory, he could not learn to play checkers, he did not care to read. And he could only learn the simplest basket work. Most of his activity consisted in just looking about him at the other patients and at the nurses, and in feeding himself at meal times. Though he could just barely move his hands and otherwise had to be moved and taken care of, nevertheless he was always cheerful, expressed himself as feeling well, and was certain of recovery.

d. Huntington's Chorea.

Progressive loss of efficiency going over to dementia, combined with constant large choreiform movements. May show hereditary tendency.

7. BRAIN TUMOR.

Dullness, with loss of memory and efficiency. May be convulsions. Placid, contented type usually. May get excited, delirious state.

8. BRAIN SYPHILIS.

This is differentiated from General Paresis in that the process seems more localized. The symptoms are confusion, or a delirious state, auditory and visual hallucinations, memory defect for recent events. Judgment, as a rule, good. The insight is present, and the patients do not tend to untidiness and delapidation, as do the General Paretics. Further symptoms are headache, possibly focal symptoms, such as paralysis; cranial nerve involvement giving vertigo, deafness, optic nerve changes, etc. Prognosis is much better than in General Paresis.

9. BRAIN ABSCESS.

Signs of infection plus those of organic brain disease, with or without focal symptoms.

10. "ORGANIC BRAIN DISEASE."

Cases in which no more definite diagnosis has been reached. Memory defect, variation in judgment, possibly epileptiform attacks. Really covers the whole group.

11. IDIOCY AND FEEBLE-MINDEDNESS.

Also called "arrested development." The causes are heredity or birth injuries to the brain. It is a question if these disorders should properly be classified here inasmuch as they are due to incomplete development of the brain, i. e., to brain absence, not brain injury.

In these folk the brain develops only incompletely, consequently there is every degree of lack of mental development to correspond. Thus we have the *idiots* who are little above the beast, make uncouth noises, have no understanding, can take no care of themselves; *imbeciles,* a little bit higher but not able to make a living, who have a

mentality equivalent to that of a child between three and eight years of age; *morons*, still higher but still of subnormal mentality, namely that of a child of eight to twelve years of age.

It is quite evident that people who are thus Feeble-minded or Mentally Defective can never have the same sense of responsibility, judgment, memory or efficiency as a normal person of the same age. Yet they are still allowed at large because they have "always been that way," and they work untold harm, having to be always supported by others, raising large families of the same shiftless kind, frequently turning to crime for a livelihood.

A large part of the daily work of the police force and jails is taken up with these mentally defective and hence irresponsible criminals. Their irresponsibility and immorality and illegitimacy cause them to be an ever growing menace. Many diseased prostitutes are recruited from this class.

12. CONSTITUTIONAL INFERIORITY.

May or may not be allied to above. The old-fashioned term "atavist" would come under this caption; also the typical "bad egg" or "black sheep" of the family. Applied to those from whose heredity and social status one would expect much, but who really seem lacking in moral and ethical sensibilities, and commit all manner of indiscretions, even crimes. This classification is often used to include the feeble-minded as well.

The patient, who was a young man of good family, aged 23, was said by his father always to have been "slow" in school, and in fact never had passed the sixth grade, leaving at the age of 16. He had always been different from his brothers and from the rest of the family who were successful financiers and factory owners. Moreover, he was headstrong and self-willed and hostile to advice, but could never make his own living.

At 18 he was sent South to work in a small town, but here he would continually get into fights with the men he had to deal with or take orders from. Besides he would drink and try to shoot up the town, trying to subdue all the toughs in all the barrooms, though he himself was only the size of a weak 14-year-old boy.

From here he was brought back to New York. He gave up drinking and became a street-corner missionary. But he "preached Hell so hot" that the other missionaries had him removed.

Then he married a girl of no greater mentality than himself, and was moved off to a nominal job in another city, and was lost sight of.

II. Psychoses of Chemical Injury to Brain Tissue—or Toxic Psychoses.

1. ALCOHOLIC PSYCHOSES.

Alcohol, as a toxic drug, causes so many and such characteristic mental disorders that it is here given a place to itself.

(a) Pathological Intoxication

Drunken furor, the type in which a man fights, beats his wife, murders, sets fire to houses, and usually has no memory of the events afterwards.

The patient, a man of 42, a constant drinker, came home one night evidently very drunk, and apparently extremely angry. He battered and pounded on the front door as he was opening it. He cursed his wife and called her obscene names. He picked up chairs and tables and smashed the other furniture and mirrors with them, cursing at his wife the while, and hurling the fragments of the furniture at his children. He finally upset the kitchen stove, bringing down the pipe, and scattering the cooking vessels and the supper all over the kitchen, roaring all sorts of broken bits of drunken obscenity.

At the police station the next day, he apparently had no memory of this event, (amnesia). He said that he remembered coming home, but nothing more. He indignantly denied the violence, and told the judge that, although he drank frequently, he rarely became intoxicated, and never to the extent described.

(b) Delirium Tremens

Generally comes after the patient has protracted his debauch until he can no longer eat or sleep. No sleep and no food plus alcohol form a disastrous combination. The characteristics are loss of sense of present situation and persons; and at the same time the patient imagines he sees and feels rats, mice, snakes, and other small animals, generally black, crawling all about the floor, the bed, the walls, himself. Often he is haunted by faces of the dead, or by a vision of the devil. There is a very marked appearance of fear—the patient seems to be in the most horrible mental torture. Recovery generally takes place unless other complications are present.

(c) Acute Hallucinosis

Is not quite the same as delirium. The patient knows the date, where he is and the persons about him. But he imagines he hears threatening or slandering voices, or he may see terrifying sights—thinks the walls are falling in on him and he must hold them up; or that a team of horses is about to run over him, etc. Often with a sardonic humor that causes him to laugh at the same minute that he is shuddering with fear (Galgen-humor); great mental anguish.

The whole hospital was aroused one evening by the sudden yelling of a patient who had just come in the previous afternoon. When he was interviewed he said that he had suddenly seen a team of two large, black horses which were just about to run over him.

He was an alcoholic and had just begun to drink more heavily. He had been having similar terrifying hallucinations for the past two days.

(d) Alcoholic Constitution

Habitual alcoholics become increasingly inefficient and unreliable. There is both an intellectual and an ethical deterioration. Profuse promises are made but never kept. Forgetfulness develops often with precocious senility. Also suspicious states leading over to

(e) Alcoholic Paranoid States

Ideas of *jealousy, persecution,* or *poisoning.* In the Delusions of Jealousy, a man will accuse his wife of infidelity, and will cling to this idea in spite of all evidence to the contrary, openly accusing her of going with other men. Not infrequently he will kill his wife when in such a disordered mental state. Many murders have been committed on this delusion as a basis.

Delusions of Persecution and Poisoning

The patient thinks that people are definitely against him to work him injury—much like the usual Paranoia, except that here there is a definite alcoholic history leading up to the psychosis.

It is a question if there is not the same mechanism underlying both forms. For we know that many cases of Paranoia represent a submerged homosexuality which is denied to consciousness. In other words, the fear is born of repressed desire. And the chronic alcoholic manifests his homosexuality through this channel, not admitting it to further consciousness, and not being able to ignore it completely.

The patient—a chronic carouser—had been married several years. He had three children. One day he accompanied his wife to a doctor's office, and there he waited in an outer waiting room while she was being treated for varicose veins of the leg. As the doctor and patient's wife emerged from his office, the doctor handed her her garter. The patient inferred from this that the doctor had had improper relations with her. He mentioned this many times to her. Also, he implicated the parish priest. The man threatened to kill his wife and the doctor, saying that he felt fully justified in doing so, and didn't care what happened to himself.

This man, also, no matter what job he held, sooner or later concluded that some certain man on the job was against him or trying to get him discharged. Thus both forms of the paranoid or delusional state were found in one patient. Abundant evidences of submerged or unrecognized homosexuality were shown in this man's record.

(f) Korsakoff's Psychosis

Loss of sense of date and place, great "holes in memory," with a compensatory lying to fill in. Connected with nerve injury, causing toe drop, etc.

Finally alcoholism may be merely a symptom of some other underlying mental disorder. A psychopathic patient readily takes to alcohol as a stimulant or refuge in a state of depression, or in case of inefficiency such as Dementia Precox or General Paresis.

2. DRUG PSYCHOSES.

All other drugs besides alcohol may also figure in drug habits.

(a) Drug habits may be regarded at times as a symptom of abnormal mental states or of an abnormal constitution. The craving for the drug seems to outweigh all other considerations whether of duty, policy, responsibility, or consideration for others. This results in extremes of unreliability as regards his outward behavior. Any drug may be thus used—opium, morphine, cocaine, heroin, chloral, ether, chloroform.

In seeking the effect of these drugs, the patient seems to be trying to escape from unpleasant thoughts or situations of strain which trouble him in moments of introspection, or which seem to hover on the margin of consciousness. These painful ideas multiply as his dissipations continue, so that to the unpleasant thoughts or mental conflicts which he originally sought to escape, are added the consciousness of

responsibilties shirked, promises broken, friendships violated, duties demanding to be met. In short, he has beset himself with added difficulties of his own making so that the only spot of pleasure he finds is this drug which he seeks more and more.

This is the reason why the habitual drug user is not apt to give up his drug, but rather to become ten times more an addict with each dose he takes. The psychological side of alcoholism, as well as other drug psychoses, is taken up in more advanced works.

The "habit" is rather the result of a disordered personality which remains constantly out of adjustment, and represents an evasion of the conflict in his mind, or living a lie. The addicts are hence constitutional liars and their consequent undependability and ethical deterioration are only to be expected. Perhaps the individual prefers this combination to the discomfort of straightening out himself and the whole situation.

Many interesting stories have been written pertaining to the state of mind of these drug addicts. (See "Spy Rock," by Henry Van Dyke, "Confessions of an English Opium Eater," by DeQuincey.)

(b) Conditions resulting from accidental poisoning with these drugs.

These generally show comatose conditions (very heavy, deep sleep from which the patient can only be momentarily aroused) or deliria—patient loses knowledge of where he is, "wanders in his mind," sees things, hears voices, imagines he is in very exciting situations, etc.

(c) Trade poisoning

This may be accidental poisoning, acute or chronic, with manifestations as above—coma, or delirium, or excitement.

(d) Illuminating Gas Poisoning

Sometimes when a very great amount of the gas has been inhaled, the patient after resuscitation is found to have great inpairment of memory. Only the most simple and usual things are remembered, thinking is largely abolished, and ambition gone. The mental horizon seems limited to the gratification of hunger, sex desire, and desire for sleep. Physically he is well and may live for years in this animal state, the brain injury being permanent.

(e) Those caused by food

The most common is the *caffeine psychosis* in its mild forms, caused by over-use of tea or coffee. It is characterized by restlessness and impatience, desire to be on the go, dropping one half-finished task to take up a new one, insomnia, and sensibility to slight sounds and colors. In fact all sensibilities are much more keen and react to much finer stimuli than normally. This sensitization is the reason why caffeine, in the form of coffee or tea, is so extensively used. It makes one feel more alive, more awake, more keen. Fatigue is correspondingly quicker in arriving, or if not, then when it does arrive is felt in much greater proportion.

Also to be mentioned are *Pellagra,* and

Ergotism, acute poisoning—confusion or coma.

Chronic (from ergot growing on rye)—depression, drowsiness and weakness, sometimes convulsions.

3. MENTAL DISORDERS COMING FROM FEVERS (i. e. INFECTIONS), FROM POISONS OF VARIOUS DISEASES, OR FROM EXHAUSTION. THE TOXIC-INFECTIVE-EXHAUSTIVE GROUP.

These are usually considered together because the results of infection are due to toxine and exhaustion also.

(a) From Fevers and Infections

Commonest is *delirium,* slight lapse from normal; surest recovery. Disorientation plus hallucinations are the characteristics of delirium.

A single woman of 34, whose past history shows a somewhat labile psychopathic disposition and a tendency toward slight depression, began to show signs of abdominal involvement—pain in the groin, tenderness over right lower quadrant, septic temperature, and sweats. The appendix was operated, but the signs continued.

Eleven days after the operation she became fretful and excited, and soon began to have visual hallucinations—thought people were looking through the ceiling at her; that the house was on fire; that a man came and dragged her about by the hair each night.

She thought the hospital was her home, and that she was in her own bed. She gave the month as April, whereas it was January. Immediately on examination she warned the doctor that there were people standing behind him to kill him. She was easily recalled by a word or two from these. Hallucinations plus disorientation indicated the presence of Delirium.

During the "Spanish Flu," or more properly Pandemic Influenza, there were many cases of mental upset which seemed due to the extreme virulence of the toxine. A very *excited form of delirium* was a frequent complication of the disease.

The patient was quietly lying in bed on the hospital porch which fortunately was screened. He suddenly jumped up and yelled, "Police, police. Send a police over here." To the crowd who immediately assembled in the street outside, he yelled, "They are trying to shanghai me here and send me away on a ship. I've got the Spanish Flu. Send a police here."

Other patients would get up and try to wander about or run out of the hospital, not knowing where they were. These excited cases usually had a fatal termination.

Depression and fatiguability seemed to be a common result of the infection, often lasting weeks. After the pandemic many cases were referred for examination whose disorder was said to have been caused by the Spanish Influenza. Certainly many of these might merely have been impending and were immediately precipitated by the infection. Certainly, also, no such drastic toxine as that which characterized the severe cases of the "Flu" would leave a person quite unscarred.

Depression with Fever or Infections. In certain cases of grippe the patient seems to have delusions of persecution and to think he or she is mistreated.

Transitory Memory Defect may sometimes result.

A Permanent Memory Defect is less common but has been known to follow Typhoid or Scarlet Fever.

(b) Toxic-Exhaustive Conditions, no fevers present, from *Uremia, Diabetes, or Eclampsia,* (toxic condition caused by pregnancy).

Usually is just a deep coma. Or there may be delirium. Or accompanied by some confusion. There may be great restlessness or irritability; the patient may wander off and arrive in another city not knowing where or who he is. The various laboratory tests known to medicine will serve to differentiate and diagnose these conditions.

THYROID.

Cretinism. Congenital absence of gland—The child is born an idiot with characteristic appearance of thick lips; protruding tongue, dull expression and coarse, dry skin. The patient improves and becomes almost normal on being treated with the gland, continually slipping back into idiocy with cessation of the treatment.

Hyperthyroidism—"Grave's Disease"—comes from over-activity of the gland, and is much like the caffeine psychosis in its symptoms. Patients are generally "worriers"; worry over everything, are apprehensive, easily excited, sleepless, easily exhausted. Show rapid heart and breathlessness. It is both toxic and exhaustive in nature, the patient's muscles have less actual power because of the toxine.

Hypothyroidism—from underactivity of the gland (also called Myxœdema). Patients on the contrary to the above become lethargic, dull, stupid, forgetful, inactive. They tend to become fat and pale and doughy looking; they always feel cold and sleepy.

(c) Exhaustive—From Extreme Loss of Sleep. Inability to grasp what is told, or remember; loss of ambition; irritability. There may be delirium.

Exhaustion plus pain, especially in the old, often leads to delirium.

A man of 72, a bookkeeper, always a hard worker, met with a fracture of the clavicle. This necessitated wearing a large plaster cast which was very uncomfortable, especially as it was hot summer time. The heat, the discomfort, the loss of sleep, the pain from the fracture were the factors. He began to become confused and forgot where he was, then would be taking part in imaginary scenes, that is, became delirious. He was brought to the hospital and the procuring of rest and easing of pain finally resulted in recovery.

DEMENTIA FROM LACK OF SLEEP MAY OCCUR.

There seems to be a suspension of judgment and self criticism and regard for consequences, the patient may be easily suggestible and commit wild acts and even crimes.

DISORDERS SHOWING FEATURES OF BOTH A. AND B.

(1) THE PSYCHOSES OF PREGNANCY

Are not a separate entity and are treated of in various parts of this syllabus, but in response to request, they have been here gathered into one group. They are of three kinds:

(a) *Toxic,* or more properly Toxic-Infective-Exhaustive.
(b) *Psychogenic*—entirely of psychic origin.
(c) *Combined Type*—showing symptoms of both the above two types.

(a) *Toxic-infective-exhaustive* may be of renal or eclamptic origin, or due to infection complicating the pregnancy. The psychoses may be:

Coma
Delirium with excitement
Convulsions may accompany either of the above and are a serious sign.

(b) *Psychogenic*—Due to the fact of the pregnancy. These may be of the type of symptoms described under

Hysteria
Anxiety Status
Depression
Manic-Depressive Psychosis
Depression with Suicidal Tendencies. This is a disorder the seriousness of which is sometimes not realized until too late, when a tragedy has occurred.

(c) *Combined*—Any combination of symptoms may and often does occur. Viz., the toxic conditions may have hysterical symptoms superimposed, etc. Also, any mental disorder may be complicated by a pregnancy.

TREATMENT.

It should now be realized that a mental disorder which means death or insanity for the patient is as urgent an indication for the termination of pregnancy as advanced pulmonary tuberculosis, or eclampsia. A *toxic psychosis* merits no other consideration, unless very mild and of an indubitably transitory nature. A *psychogenic disorder* likewise.

A Reactionary Suicidal Depression may be more rapidly fatal than either of the above two previously recognized physical indications for termination of pregnancy.

Practice will vary among physicians according to their beliefs, and the fact that the woman happens to be unmarried will cause some physicians to say "Hands off," though the patient end her life in the next hour. Whether the pregnancy is legitimate or illegitimate makes no difference. It is time that we separated our double standard of morality from our ideas of medicine. The purpose of medicine is to save life. No man would impose on another man the death penalty merely for illicit sexual intercourse. Nor should physicians for similar reasons impose upon women what they would not impose upon other men nor upon members of their own immediate families.

Accordingly, as soon as the diagnosis is definitely established, it is my opinion that pregnancy should be immediately terminated, either by

curettage or induced delivery, since delay gains nothing and may mean death or a permanent psychosis which might otherwise have been avoided.

POST PARTUM PSYCHOSES.

After delivery certain psychoses may develop. It may be difficult to state whether they have been the result of the pregnancy or were impending at the time. In some cases the psychosis may be referred to the infectious group—the infection being a more or less mild "puerperal fever." Certain psychoses seem to have been impending and occurred without regard to events just preceding their appearance, as for instance a Dementia Precox which often develops without as well as with so great a physical and serological change as pregnancy. On the other hand a pregnancy may precipitate a psychosis, either toxic or psychogenic, that might otherwise never have occurred.

(2) EPILEPSY—CONVULSIVE ATTACKS.

The causes of epileptic attacks are not clearly established in all cases. In some cases as above they are the definite results of brain disease such as a tumor. In what is commonly called Epilepsy ("Idiopathic Epilepsy") there seems to be no organic basis yet discovered which could account for the convulsive attacks. These two types are marked by loss of consciousness during the attack. The patient is apt to bite his tongue and to wet or soil himself. The attack may come on at any time, in any place. Others seem to be of the same type attack but coming only in response to a certain highly charged emotional setting.

In some other cases the attacks seem to have developed entirely as a symptom of Hysteria (Hitschman—"Freud's Theories of the Neuroses") so that some cases should certainly be classified under that heading. The hysterical epileptic attacks often are not accompanied by loss of consciousness, the patient as a rule remembers what goes on around him or her. Whether most cases of epilepsy are approachable and remediable under that conception has yet to be discovered.

We do know, however, that most cases of the spontaneous epilepsy do show a certain *Epileptic Constitution* or *Epileptic Disposition*. They are as a rule restless, often habitually irritable, said by some to be constantly trying to put forward their own views and draw attention to themselves. This restlessness at times leads to extreme industry, and epileptics have had, and do hold, extremely important positions. Napoleon, for instance, was an epileptic, and once while he was asleep during an important battle it was said to be because he was having an epileptic attack.

Their piety or religious fervor has been marked by others, and this tendency towards religion seems to be more than a surface ritual, but rather a part of their constitution. It is well known that just before or after the convulsion, many epileptics feel as if they were

related to God and had the same omnipotent power. I felt as if anything I willed would have to take place," said one epileptic boy of his feelings before an attack. A very good picture of this ecstasy is given in Dostoieffsky's "The Idiot," which is the Russian term for epileptic. The Christlike character of the hero, Prince Muishkin, is a good study of the altruistic epileptic.

In connection with the omnipotent feeling of power, it is interesting to note that three great world conquerors: Alexander the Great, who sighed for more worlds to conquer, Julius Cæsar, who conquered the Gauls, and Napoleon were epileptics. It shows what a man of great intelligence with possibility for power may do if possessed of this epileptic "I am invincible" type of mind.

The sudden discharge of energy characteristic of Epilepsy may take place in forms other than the usual convulsions. These have been termed "Epileptic Equivalents." Thus, in place of a convulsive attack of unconsciousness, a sudden attack of violence may take place, with forgetfulness of the whole occurrence afterward. Or the patient may steal. Or he may suddenly and unaccountably drop everything and wander away from home, leaving family, friends and position, without a word to anyone. There just seems to come to him an overpowering impulse to move on. These sudden wanderings are called by the French "Fugues."

Sometimes sudden, periodic impulsive attacks of drinking are really epileptic equivalents. The patient may go for weeks or months without a drink, then suddenly he begins and takes one drink right after another until intoxicated. He may be found by his friends in low resorts, or come to consciousness himself. After the attack he may be depressed and self-accusatory and quite industrious and efficient until the next attack.

B. MENTAL DISORDERS EXPLICABLE IN PSYCHOLOGICAL TERMS—THE EMOTIONAL DISTURBANCES

EMOTION GUIDES BEHAVIOR.

If the preceding half of the book has dealt almost exclusively with conditions that belong to the realm of general medicine, this section that follows is just as completely a matter of human nature and everyday experience.

The psychogenic disorders are disturbances of the emotional nature. They are a matter of personality, interest, tastes, development and personal experience rather than a question of accidental injury or disease. Their nature is personal and the active processes are personal, not external. We here deal more with the individual life and less with an attempt to vary impersonal conditions.

When at any time we come to study the behavior of an individual, we find that action is very largely the result of mood, or emotional color or affect—not a matter of pure, cold reason. To use a crude example, we patronize a certain store because we have a warm glow of cheery associations with that store; we avoid certain streets because they are unpleasant to us. It is easier to buy a thing we *want* than a thing we *need*. The successful salesman is very cognizant of this and immediately seeks to establish pleasant relations with his prospective customers—to interest them, to tickle their vanity, etc. So that "Arousing Favorable Interest" is the first step in salesmanship as taught in the text-books and "salesmanship courses."

It is almost impossible to overestimate the role of emotion in our everyday life and action. Many of the most important steps in a man's or woman's life, viz., the choosing of a career, are made on a basis in which emotion has a very large, if not the preponderating, part.

Let us consider the naive description given by Philip Jourdon of the manner in which he fell in love with Cecil Rhodes—which led to his becoming the latter's secretary and thus determined the course of his life for years afterwards.

"It was about a year after I first met him that an almost uncontrollable desire took hold of me to be his private secretary and to travel over the world with him. In my mind I had placed him on such a high pinnacle of fame that such a wish seemed almost impossible of realization. Sometimes I felt I dared not even think of it. It was my great secret and I did not communicate it to a soul. I delighted to harbor the idea, and sometimes I would lie awake half the night working myself up into a state of delirious excitement speculating on the joy and pleasure which would be mine when I should be his secretary, when I should be always with him and would go wherever he went. I had not then received the slightest hint from him that there was even a possibility of my appointment as his secretary. I worshipped him and had an intense desire to work for him and to please him."

For other examples, one need but consider the accounts of history and literature to see the power that that very subtle and complex emotion which we call love has to influence the lives of people, and through them even the destinies of empires.

And emotion is, in turn, essentially of the subconscious.* Made up of inherited qualities, from pleasant or painful associations gathered daily and hourly from the moment of birth onward they come suddenly out of the dark domain of our mind to flood our consciousness and sweep us over the barrier of quiescence into activity. We merely act because we want to—we don't know why. We have been directed by our subconscious.

The evolution of feeling outward into thought and action is neatly described by Edward Carpenter:

"Feeling (or desire) lies beneath. Thought is the form which it takes as it comes into the outer world. Let us take a definite instance. We desire to travel. The desire begins first as a mere vague sense of discomfort or restlessness; presently it takes shape as a wish to leave home or to visit other regions. It may remain at that for some time; then it takes somewhat more definite shape—as to go to the seaside. Then we consult our wife, we consider ways and means, we fumble through Bradshaw, the thought of Margate comes as a kind of inspiration, and a quite distinct and clearly formed plan emerges.

"Or we wish to build ourselves a house of our own. For a long time this may only be a kind of cloudy pious aspiration. But at last and almost inevitably, the dream of the house takes shape within our minds. We get so far as to make a pencil sketch of what we want. We go and prospect a site. We consult an architect, and presently there emerges a much more definite and detailed plan than before. Then steps are actually taken towards building. Heaps of bricks and stone and other material begin to appear on the scene; and at last there is the house standing, which once only existed in the dream-world of our minds. Always the movement is outward, from the indefinite vague Feeling or desire to the definite clearly formed Thought, and thence to Action and the External World."

So that we may say that action or behavior is largely a function of the subconscious, its motive power being emotion. Probably most of our behavior is a result of this almost automatic functioning.

The terms "normal" and "abnormal" are arbitrary and indicate degree of reaction—not kind of reaction. Because only when this automatic behavior—our likes and dislikes, our loves and hates, our boldnesses and fears—are in general much like those of most of the people around us, our social group, do we call it normal and accept it as such. But codes of behavior vary greatly among different races, Oriental and Occidental, savage and civilized, tropical and of temperate zone,

*(Whereas we will here employ the old distinction of conscious mind and subconscious or unconscious mind as if there were a sharp line dividing them, nevertheless we must realize that what is subconscious or unconscious is continually becoming conscious in the form of memories, phantasies, imaginations, and the like; and what is conscious is continually dropping into the unconscious or subconscious, is being forgotten, and either takes place instantaneously. Conscious, semi-conscious, and subconscious are artificial divisions laid out on one continuous piece of material.)

and just as much among the different social strata of the same race. A gamin of the streets is brought up on a very different code than a judge-advocate, a workman than a financial man. Herein perhaps lies much of the dissension in life.

Now, "unusual behavior" or "abnormal behavior" is merely that which is different from our usually accepted code, and varies widely acccording to the code we adopt as standard. The terms are relative only. Very often behavior or action which may at first look very queer, turns out to be very commonplace when we discover the person's avowed purpose for so doing. For instance:

A young woman strolling one Sunday morning in the square about the Washington Monument was suddenly struck by seeing a man half bowing, half in a genuflection before one of the statues that adorn that vicinity. Immediately she felt herself in the presence of a lunatic, and in some perhaps unguessed danger. In surprise and fear she clutched her companion and screamed, "Look, Look!" pointing. The man then gravely turned around and the girl finally saw that he had a kodak in his hands and had been merely trying to get a good focus on the statue. The girl was so relieved that she collapsed on some nearby steps, overcome with laughter.

Perhaps all behavior would in the same way be comprehensible to us if we could see clues to the workings of the individual's mind behind it, i. e., if we could trace back of the action a familiar motive; that is, one which we feel in ourselves.

In fact all abnormal behavior when subjected to analysis shows us practically the same underlying forces at work as normal behavior, being only extreme behavior, not abnormal.

But the point is that we often do not see these motives behind the patient's actions, generally the patient does not himself. His behavior taken broadly is merely reaction to stimulus and the reason that the patient can not control his abnormal behavior is because he does not control his normal behavior. It is our task, then, to increase our insight into the patient's mind.

Therefore, in studying the psychogenic disorders, we wish to differentiate the various forms of thought disorders or unusual thought life as shown by their outward manifestation, namely speech and behavior. Then, bearing in mind that we are going to find the same factors at work which activate ourselves, we try to discover as far as possible the emotional state lying beneath these symptoms. Finally we wish to arrive at the causes of this emotional state.

I. THE ELATION-DEPRESSION OSCILLATION

Or Manic-Depressive Psychosis.

This seems to be an exaggerated form of reactions which are commonly found in normal life. All of us have felt *elated* at various times, but in the course of a little while—hours or minutes, perhaps—the extreme elation has diminished, and in a few days or less all effects

have disappeared. If this elation keeps up in the heightened state for days, or if it continues to increase and increase in intensity it becomes a chronic elation or manic condition.

Likewise, *depression* which comes to everyone some time or other in varying degree and duration, if it tends to endure becomes an abnormal state. And either elation or depression once established, it is well known medically, might change very quickly into the other.

a. *The Characteristics of approaching Elation, or Hypomanic State.*

The onset may take days or weeks, the patient's mood gradually becoming more and more excited. The patient begins to feel more keen, more wide-awake, more active and efficient than ever before. He feels a notable increase in his ability to calculate and to plan and to handle a multitude of details (lifting of inhibitions). His mind seems clearer and he can jump more readily from idea to idea, from plan to plan. He needs less sleep than before. Added to this he is elated; he "feels fine," he "just touches the high spots," "business never went so well before," "this is a fine old world," etc., (hypomania).

So far everything is to the good one might say and perhaps all of us should normally feel a little more keen, a little more active, a little better able to handle our work. Perhaps also we would, if we were doing only such work as we were intensely interested in and fitted for. If the disorder stopped here all would be well and it has sometimes happened that a large business has been developed by a man in this hypersanguine state.

But to his friends and associates the manic patient begins to seem a little too optimistic; he may seem to overestimate his strength, his gayety may seem a little more enduring than every occasion calls for, his laugh may seem a trifle too frequent and too hearty. And this soon continues beyond all bounds of doubt. Fantastic schemes are entered into, gigantic financial projects are launched certain of failure; the patient works feverishly day and night trying to bolster up the colossal but insecure structures he has thrown up.

But it is no go and if he is not quickly taken care of the world comes tumbling about his ears. The various impossible projects fail, creditors appear, wild escapades bring demands for retribution. This state may be almost as disastrous for the time being as General Paresis, but there are many redeeming features, the patient usually remembers and can give an account of what he has done; and recovery usually takes place.

But what is the patient's behavior as the elation increases?

CHARACTERISTICS OF MANIC STATE.

He is very active moving about his room rapidly or talking away—there seems to be great press of activity. It seems as if something inside keeps him on the go. In his speech he shows a rapidity both

of words and ideas, he jumps quickly from subject to subject, and from word to word, apparently with but the most superficial association from one to another. He can be easily distracted and his line of talk shifted by any slight movement or noise about him. Viz.: if, during his stream of talk keys are rattled, somewhat this result will happen: "Millions—trillions—quadrillions—(keys jingled) keys—I've got 'em—you've got 'em—keys to Heaven—God—Heavenly Father—angels—golden hair—gold—money," etc.

He is extremely elated, self criticism has long ago been forgotten, he laughs and makes noises and smiles at all about him.

At times a patient presents an irritable or ill-tempered mania—hyperactivity, rapidity of speech with corresponding shallowness of thought combined with irritation and combativeness. This is rather rare.

Finally, much purposeless action, more like playing, is the result. He saves and files away pieces of paper, pages from magazines, etc.; decorates his room with all manner of bright objects, materials, and wearing apparel. He, apparently in fun, miscalls names, gives all around him fictitious names and titles, and goes through imaginary scenes with them in which he himself plays the leading part. He is an explorer, a conqueror, or a king.

The whole picture strikes one at times as play acting, and the superficiality of thought association bears this out. The situation seems to be a way of escape from some mental conflict which may or may not be discovered on investigation. It is like laughing to cover embarrassment.

This reaction tends to recovery from the attack in most cases, which may take place in a few days or not until after months. There is very often a tendency to recurrence, and a fourth or fifth attack is apt to be much slower at clearing up than the first or second. Elation may alternate with depression.

(b) Depression.

Here we have just the opposite picture to the above. Instead of feeling happy, the patient feels always "blue" or depressed. He is quite inactive and does things only with greatest difficulty. Speech, thought, and action are all slow. All his inhibitions seem increased to an almost overwhelming degree. A decision seems sometimes impossible for him to make. He will decide to go out and take a walk, get to the door, and want to go back; then wish he were out on the street. After much mental agony he may get out, then it is difficult to decide what street to follow, or whether he should take a street car, and which one; or whether he hadn't better return at once; but he should get exercise, etc., etc.

In addition he may be very self critical and have ideas of his own unworthiness and accuse himself of being a failure, unworthy, poverty-stricken, a thief. He may think that through him the whole family is reduced to poverty.

Just as elation or depression may readily change one into the other, so also we sometimes find the symptoms of the two types intermingled.

The inaccessibility of the patient in either the manic or the depressed phase would suggest that the psychosis is a trick of the subconscious to avoid some painful combination of thoughts; and in this regard it would seem to be a "protective insanity," rather than an "overwhelming insanity."

A college professor who had all his life had periods of months in which he felt particularly active and efficient—work went particularly well—alternating with periods of months in which work, especially new creative work, seemed almost impossible. (Mild elated or depressed attacks, i. e., manic-depressive constitution). At the age of 59 he felt constantly increasing difficulty in his work until it finally seemed impossible. His attempts to resist this finally ended in a fainting attack during some exercises in which he was taking part, and from which he had to be carried.

Following this his depression was so well established that it necessitated his removal to the hospital. On entrance he was quite despondent. He answered only very slowly and after considerable pause. He tended to blame himself very severely for matters which he had thought quite satisfactory at the time, but in which he now saw cause for self-reproach, namely matters of administration, and some sexual conflicts. Memory was unimpaired, but the process of recalling events was delayed somewhat by the slowness of association processes. Calculation was likewise delayed. Orientation was clear. The man had clear insight.

After some months of this depression the mood began to change, the great inhibition began to lift, his normal processes became more facile, and he began to assume a normal appearance. This, however, lasted only a few days. Inhibitions were removed more and more. The previously deeply melancholy professor became jolly, then elated. He became talkative, entertained his fellow patients with risqué stories such as he had never employed before. This elation gradually increased until the manic phase was reached. The patient rose at four in the morning, danced all day, wrote innumerable epistles and haphazard articles consisting of paragraphs of merely a sentence or two, or just a few words. He wrote a poem to his wife which had a rather presentable lyrical quality.

After several months of this he became more and more quiet until a period of normal mood and thought action were reached, in which condition he left the hospital.

Mild grades of this manic-depressive reaction are called Cyclothymia. In this the patient shows elation or depression which is beyond the bounds of normal behavior but never reaches the extremes described above. Sometimes, however, these abnormalities of mood and judgment are overlooked at the time.

2. DEPRESSIONS APPARENTLY NOT OF THE MANIC-DEPRESSIVE GROUP.

(a) Those incidental to certain diseases, such as some heart conditions, fatigue; convalescence from certain diseases—Influenza, Tonsilitis, etc. These should be perhaps listed under the toxic-exhaustive group, but there is probably a combination of both physical and psy-

chogenic causes, i. e., the depression may be partly due to the weakness, but no less due also to the confinement, or to the inability to act or think which is experienced.

(b) Depression with hallucinations, i. e., "seeing things" (visual), or "hearing things," usually voices, (auditory). The manic-depressive depression is free from hallucinations, and their presence generally indicates much more serious prognosis.

(c) Depression with paranoid trends, i. e., Delusions of Persecution. In some cases these seem incidental to the depression and disappear as the depression disappears. Prognosis here much better than in Paranoia without depression.

A man of 52 entered the clinic, being markedly depressed and self-accusatory. He upbraided himself for having committed several sharp practices in business, and stated that his wife was getting a divorce from him. He had always been of the manic-depressive constitution, either very jolly, or so depressed that he would not speak to his family for a week. There had been several emotional factors in his personal life, fear of having children, which neither he nor his wife desired, fear of infecting his wife (he had acquired lues some years previous), and recently a loss of potentia.

His depression continued and got worse, and he became more self-accusatory. Soon he began to develop paranoid ideas: Because of his business dealings, he was going to be sent to the penitentiary. Everyone in the hospital was in a conspiracy against him to arrange this. Whenever the doctor patted him on the shoulder, it had some hidden meaning, though just what this was he didn't know.

After some weeks the depression began to lighten and he became less despondent and less self-accusatory. At the same time the ideas of the conspiracy against him, the deep significance for himself which he attached to the actions of everyone else, disappeared. The paranoid ideas had merely been a phase of, or had been incidental to, the depression.

In some cases, however, the delusions seem more permanently established. It is often difficult to differentiate these two types in order to give prognosis until after long observation of the patient.

(d) Agitated Depression—more properly often the end stage of an Anxiety Neurosis (see below). The patient is constantly weeping and is apprehensive and is depressed. He or she accuses himself and worries and is inconsolable. This forms a vicious circle: The worry and self-accusation and sleeplessness cause the patient to be in turn more worried, agitated and restless.

3. ATYPICAL EXCITEMENTS.

Excitements which are not typical of the manic excitement nor yet showing deterioration.

A young man of 28 who came of unassuming laboring stock, had by dint of much effort and thinking, raised himself above his surroundings to the extent of becoming a broker's clerk. From there he changed to other offices, always doing a good deal of calculating and dabbling in business deals. After several months of over-time work, which kept him at the office until all hours at night, he became excited.

On entrance to the hospital he was rather elated and smiled pleasantly as if happy. He kept repeating, "I played the game to win. I played the game to

win." But though he was elated, there was only slight flight of ideas, and there seemed to be no press of activity. When addressed he would answer briefly and smile, but would talk very little.

As the excitement abated, he became quiet and had more difficulty in answering, waiting an appreciable space of several seconds before replying. He took little interest in amusements and light occupational work, and would sit for hours in a lethargic state, semi-smiling, and following the nurse or attendant about with his eyes. This retarded condition persisted for some weeks.

We hence have in this case symptoms of the Manic-Depressive and also of the Schizophrenic reaction types, but not conclusive for either.

4. PARANOIA OR DELUSIONAL STATE.

Delusions which may be Persecutory, Grandiose, or Erotic. No Deterioration present.

The term *paranoia* is usually reserved for delusions of persecution, but it really covers all the delusional states including the delusions of grandeur and erotic delusions. A patient who has one delusion is apt to have several, thus a patient who thinks everyone is against him (persecutory) may be said to be grandiose in his self-importance. A man with megalomanic or grandiose ideas, i. e., who thinks he is tremendously wise or rich or powerful in the face of obvious evidence to the contrary, may soon, because other people take the contrary view, believe that everyone is in league against him. A man may think that some very prominent woman whom he has never met is in love with him, that he has a great attractiveness and a great power which she feels. Then an erotic and a grandiose delusion occur together.

The classic picture is of a patient who thinks people are against him, or are even making attempts on his life through poisoning or causing accidents to happen to him, or there may be an organized movement on foot to do him harm. (Persecutory Type). Everyone is then placed in the hostile combine, and every occurrence of his life, every person he meets, his words, actions, etc., all are given special significance as being concerned directly with him. This is the most difficult of all diseases to treat, as it is impossible to get the patient's confidence and coöperation. For as a rule he places the doctor immediately among his enemies, and this ends any further satisfactory interviews.

Persons who have this form of disorder are often dangerous. It can be easily seen that if the patient thinks a certain person is making attempts against his life, he will consider the best plan is to kill this person at once and so remove him from his path. Under such delusions many murders are committed. Some authorities claim that only those paranoiacs are dangerous in whom there is also deterioration but it is very difficult to draw the line here.

The patient, a man of 38, single, a mail-carrier, had always been seclusive, without friends or confidants. He was the oldest of the family, there being a younger brother and two sisters, and the patient was always domineering towards them, especially the brother, and insisting on having his way. Of late years he

had been very aggressive toward his brother, saying that he was trying to master him. Frequently he would say, "You do anything to me and I will get you for it."

He further thought that people along his route were planning something against him, so that he had quarreled with every one of them. Moreover, he had thrown rocks against the house of a certain girl cousin, and on one occasion had exploded a stick of dynamite on her doorstep.

It is impossible to say definitely whether this disease rests upon organic disturbance or upon functional grounds, i. e., upon factors which can be discussed entirely in the light of psychology. The balance of opinion seems of late years to favor the psychological interpretation of the disease. Such patients, long before developing paranoia, show a particular disposition. They seem inordinately welded to their own ideas, and will not change them even after experiences that would prove themselves wrong. There seems present a very exaggerated self-importance and self-esteem, amounting to overwhelming self-love. This makes himself the center of all his attention and hence, he judges, of other people's. The step from this self-importance to feeling that people are persecuting him is easy. He regards himself so highly that he thinks others regard him with equal importance. Everything that anyone says has a personal reference to himself (ideas of reference). Soon he thinks that everyone must be jealous of him. The origin of this self-love, or narcism, will be taken up later. Suffice it to say here that it seems to be an infantile reaction which gives a feeling of comfort or pleasure, and is a way of escape from unpleasant mental conflicts.

True paranoia (without apparent deterioration) is to be differentiated from Paranoid Dementia Precox of which deterioration is an outstanding characteristic.

5. DEMENTIA PRECOX.

Also called *Insanity of Adolescence,* or *Schizophrenia.*

The terms mean much the same. Dementia Precox means *early dementia;* namely, a mental disorder coming on in overwhelming proportions about at adolescence. Schizophrenia means a splitting of thought-processes. This conception advances us little, however, beyond what is covered by the term insanity or dementia, though it perhaps would suggest a disorder not of structural origin.

Though the disorder is probably a matter of gradual development, the onset may go unnoticed until the parents or friends are suddenly surprised by a great and rapid change in the patient's personality. The girl or boy may find himself unable to concentrate his attention on the external world and to do any work that requires such attention. And he may be equally unable to describe what is the nature of his disorder. In short, a very sudden and extensive confusion has taken place. This is the full blown disorder. Hence it seems advisable to us to describe the disorder in its earlier and less obvious stages.

DEVELOPMENT STAGE OR PRE-DEMENTIA PRECOX.

It seems fair to embody this as part of the account since in most cases the disorder has occurred in a certain definite type of personality—called the "shut in," really "driven in," personality. The boy or girl is introspective, subjective, his interest is apparently turned in on himself, he has no confidant to whom he can unbosom himself—perhaps he feels so deeply that the feeling is inarticulate. He prefers to be alone rather than in company, is seclusive, shy, sensitive, easily embarrassed. This description fits equally many youths of both sexes who through the vicissitudes of development and education come to adolescence unconscious of their forces, and unprepared for self direction. One of the characteristics of adolescence is inarticulateness. Some further unknown factor, however, seems to be necessary to precipitate the tragedy.

Another pre-Dementia type seems to include persons who, through inferior mental capacity, habitually bungle situation after situation, becoming discouraged and then more bungling and finally develop the final condition described as Dementia Precox.

Any mental disturbance, then, in a young person during the years of adolescence should immediately be regarded with the greatest seriousness. And a sudden change in personality occurring in a hyper-sensitive and introspective girl or boy with inability to do any work (often misconstrued as intentional unwillingness) combined with an inability to explain his difficulty, is apt to be evidence of the presence of this psychosis.

CHARACTERISTICS OF DEMENTIA PRECOX

These symptoms occur in a frequently changing variety of combination, and no description of the disorder is adequate unless it embodies this idea of continual change from one picture to another. It must be, as it were, a motion-picture in words. Four commonly occurring phases or pictures or types have been used. But all the features of one often do not occur together and sometimes one or more features of other types may be present. The types are:

(a) Simple Type
(b) Hebephrenic
(c) Catatonic
(d) Paranoid

(a) Simple Type.

The patient who may have been a brilliant boy or girl gradually begins to avoid company or the family, and keeps to himself. There seems to be a gradual but very marked change in the personality. He may sit for hours absorbed in day dreams, or reminiscences, or spinning idle plans or fantasies which he does not try to carry into action.

It seems much as if the mental processes were blocked at the point where they flow out into action, as if but endless reflection were allowed.

He may be irritable or evidently worrying; perhaps he cannot sleep at night, and he alarms the family by arising and wandering about, restless and unhappy. There may be sudden unaccountable outbursts of weeping, or of excitement, or of temper. He may attach undue importance to insignificant incidents, thinking that every remark he hears is being made about him, whenever he sees anyone laugh that person is laughing at him, etc. Further inquiry may elicit a history of excessive indulgence in masturbation. This taken with the endless fancies which result in no action would seem to indicate a turning in of the interest on himself with a resulting loss of interest in making sorties into the outside world.

To all questions he probably answers that he does not feel well, perhaps he cannot name his difficulty. He may go to bed and spend all his time there, and people remark on the strangeness of a person apparently not sick, who can converse clearly, keeps track of days and current events, yet seems unwilling, though really unable, to do anything.

A young man of 21 was in the second year of college. He had always been very sincere, serious, conscientious, and applied himself very studiously to his lessons. He had always been interested in debating, but this usually meant a great struggle between the things his intellect prompted him to say, and his self-consciousness which hindered him from doing so. After a period of long preparation for the critical debate of the year, he had been given the major part for his side. Being suddenly overcome with self-consciousness, he made a fizzle of his speech and lost the debate.

From then on he felt different. He was never able to concentrate on his work, so that he did his lessons but very poorly. He was very self-reproachful over this, but seemed unable to remedy it. He was troubled by frequent attacks of drowsiness and his head ached frequently. His inability to concentrate or to carry out any plans continued to be a source of discouragement to him, and he was able only to spend his time in reminiscences and idle planning.

The type remains simple and recovery may take place, as long as no fantastic changes have developed. That is, as long as it has not entered any of the following phases. So that for practical purposes we might speak of two types of Dementia Precox:

(1) Without fantastic developments

(2) With fantastic developments

The remaining types are commonly spoken of specifically and are hence described.

(b) Hebephrenic Type

This reaction type is characterized by inability to concentrate on any mental work and by an exaggeration of his usual traits with affectation, superciliousness, or silly behavior. There is deterioration and development of many odd ideas and actions without the appearance of either the catatonic or paranoid reactions.

PROGRESS OF THE DISEASE.

As the disease *progresses* we begin to get a more sinister picture. Here hallucinations may appear, i. e., imagination of seeing visions or hearing voices; or delusions, i. e., false ideas which the patient seems unable to correct in spite of abundant proof to the contrary, viz., he may imagine his body has become an empty shell, or that he is influenced to act one way or the other.

He may see God in a vision or talk with Him, or he may feel himself gifted with divine power or entrusted with a divine mission.

He may make many curious remarks which to him contain manifold hidden meanings, or he may have a certain symbolic mark he puts upon everything, indicating that this contains great hidden significance.

On the other hand sudden yelling or violence or an attempt to escape may be carried on as a result of an inward prompting to make some heroic effort and avoid some imagined catastrophe.

Complicating any of the above he may enter either of the following states:

(c) Catatonic Type or Catatonic State.

This generally has a gradual development such as described under Simple Type.

This catatonic state is characterized by a condition of muscular rigidity, the opposing sets of muscles being kept taut and tense, and the limbs being held rigid. This muscular tension is so persistent that it gives a certain "waxy flexibility" to the arms or legs; that is, if an arm of the patient be lifted up by someone and held in an outstretched position for a minute or so, then let go, it may be maintained in this position for some minutes—often far beyond the time a normal person would be able to maintain it in this position.

The rigidity seems to be an abortive sort of resistance on the part of the patient against the disorder, perhaps against an indefinite something. Unfortunately this may be exhibited as resistance to the person who is trying to minister to his maintenance. (Sometimes when the patient refuses food and drink, etc., it seems a definite attempt towards suicide, as is borne out by other remarks and actions.) It may be that this is an attempt to imitate the prenatal quiescence. Many other characteristic symptoms have been noted, among them mutism or refusal to talk, stereotypie or stereotyped movements which are repeated over and over and over hundreds of times with a machine-like persistence.

There is the so-called *Catatonic Stupor,* in which the patient lies rigid, motionless in bed, day in, day out, night in, night out, refusing to empty his bladder or allow his bowels to move. All functions have to be carried out artificially—feeding is done by a tube, urine obtained

by catheter, etc. The patient is by no means in a stupor, though; and perception and memory are thoroughly keen and alert. This is demonstrated by occasional remarks of the patient which show that he has taken in all that has been said or done in his presence; or when at some later date the disorder seems to clear up for a time, and the patient talks normally, and explains his experiences and behavior while in the previous immobile state.

There is also the stage of *Catatonic Excitement* in which the patient screams or suddenly does impulsive peculiar things. He may suddenly get up and jump out of the window, or smash something, or hit someone. He may lie screaming for hours. Though to superficial observation he apparently cannot be reasoned with, the key to the situation seems to be that he acts in this way in response to an inner command or conviction. Perhaps he hears an imaginary voice telling him to act in this way—a message from God perhaps.

The patient, a young man of 21, always bright, an honor man at college, sensitive, idealistic, went through an experience which he described as feeling like a "block in thought." He finally passed into the following condition. He lay rigid in bed with eyes closed. He would not answer when spoken to except occasionally to speak of his own unworthiness. He would not swallow food when it was put into his mouth, and had to be fed by tube. His whole reaction was a means of resistance to, or protest against, something in his situation, as shown by the fact that he at times tried to throw himself out of bed on to the floor on his head. With the exception of some remissions, when he would be up—though even then standing rigid—he continued in this catatonic condition, being tube-fed and physically cared for, and after some months died.

(d) Paranoid Dementia Precox.

This type as a rule shows some premonitory symptoms, but there may be a sudden onset with at once the appearance of this fully developed picture. This type is characterized by the fact that the patient presents delusions of grandeur or persecution which are more or less systematized. It presents paranoia plus deterioration. Usually he considers that someone is definitely working against him, perhaps intending to poison him or kill him in some other way. He may think someone is putting poison in his food and then refuse to eat or drink. This is usually a serious sign. He often thinks everyone he knows is combined in a "ring" against him. It seems as if the patient thought that his mental difficulty arose because some individual is influencing him through electricity, mesmerism, telepathy, wireless telegraphy, or practically any invisible influence that he has heard of.

If he hears voices, they may belong to a certain person who is thus directing him. Or these voices may call him names or talk slanderously of him. He refuses to refer his condition to his own disintegration or confusion but projects it, that is, he blames someone else for his inability to think. The patient may get very angry at this person or persons he supposes are controlling him, and try to annihilate them.

Therein lies the danger from these cases. Always while they are at large these patients are potentially dangerous. Hence the necessity of permanent institutional care.

Paranoid Dementia Precox is differentiated from ordinary Paranoia by the presence of deterioration, and often also of hallucinations. In true Paranoia there is apparently no other mental impairment outside of the delusions themselves.

The patient, aged 26, was a young Jewish man, the son of poor immigrant parents. The patient was idealistic, and strove in every way to improve the family situation, being especially attached to his mother and she to him. He early studied law, but went to work as a stenographer for the B. & O. He managed thus to help his family, and they moved from the slums to a nice house near the park.

After being with the B. & O. some months he was discharged. (Possibly his deterioration had begun.) He explained this, saying that a request had come for criticisms of the railroad management, and he had written a letter to President Willard, stating that many office employees were doing only nominal work. He never received an answer, and concluded from the actions of those about him that his letter had been referred back to his department head, that he had been regarded as a trouble-maker; and that for this reason he was discharged.

For one and a half years following he tried to secure a position but was unable to, though he saw many young men of no greater ability being given jobs. Hence he concluded that the B. & O. were trying to keep him from securing a position. (This seems as if his capacity for work had suffered a severe change recognized by everyone but himself.)

He then decided to go to Hopewell, Va., but took the wrong boat down, he thinks due to his having been influenced by someone. On arrival he was given bare living quarters; also he saw some men who he thought were detectives shadowing him. And so he concluded that the munition makers were in league with the B. & O. against him. Whenever a whistle blew, it was to make his conscience trouble him.

He returned home and for five nights lay awake until he finally saw that for years an influence had been working against him.

At times a black spot was made to fall about him as he worked which his fellow-men could see. He would have a vision of a certain figure before him. All this was due to a scientific optical illusion brought about by the same conspiracy against him. Moreover, he was made to have seminal emissions by the same power, heard voices speaking in his ear, and was troubled by visions of all manner of lewd sexual imagery.

After some months of this paranoia, plus inability to concentrate, he became vengeful and wanted no one to enter his house. He threatened everyone who came in. His family considered him so dangerous that they had him confined to an institution.

I would impress upon the reader the fact that the above so-called types are merely varying phases of one and the same very complicated emotional disturbance, and that the distinctions between them at best are but very crude. The descriptions of all four should be taken together as the description of one entity. By reading them several times together, common characteristics and a general relationship will gradually appear so that when one type is seen, the possibilities of all other types will be kept in mind.

DISCUSSION OF CAUSES OF DEMENTIA PRECOX.

The theories to account for Dementia Precox are of two kinds.

1. The first type holds that the symptoms of mental disturbance as shown by unusual speech and actions are the result of a toxine acting on the cortex, or of actual changes taking place in the cortex itself, either toxine or physical change being too subtle to be demonstrated by our present laboratory methods. Abnormal secretion on the part of the thyroid, adrenal, or the chromaffin system have been suspected, also gliosis of the cortex.

All that can be said for such a theory is that as yet nothing definite has been demonstrated; though no doubt all would hail such a discovery with great satisfaction.

2. The second theory is that mind or mental processes can suffer a deterioration of themselves through faulty mental habits or faulty development of instincts, or by being inhibited; that is, that there can be a functional deterioration of the mind itself.

The discoveries in the realm of the subconscious tend to show that such a theory is possible; discoveries such as the capacity of the subconscious for retaining memories and for combining memories into plans or inventions; and, on the other hand, the inhibition of thought activity, the inhibition of the combination of images into plans and the inhibition of the conversion of plans into action, by constellations of painful memories, which may take place within its borders.

It is a theory of the functional development of Dementia Precox which we ourselves wish to offer for consideration, not taking issue with any other theories of the causation of Dementia Precox but merely attempting to explain its development for a certain and perhaps restricted group of cases.

The theory here maintained in brief is this: The main feature of Dementia Precox is that referred to as "deterioration" or "block in thought," i. e., the inability to concentrate, and all other symptoms such as mysticism, religious tendencies, symbolism, sterotypie, are consequent upon this interference with thought activity; and this thought-blocking itself is due to a multiform and overwhelming inhibition arising within the patient's subconscious.

As to the fantastic symptoms being secondary to the thought interference, we can see that religious quotations invariably refer back to a lack of mental activity in the person who quotes, in this case the patient. It is always easier to quote than to formulate the situation in words for one's self. And as Biblical quotations form many of our earliest and most lasting and most significant memories, when our own words fail us in describing a situation, we reach into a memory pigeon-hole and pull out a Biblical quotation to fit. Religious behavior is likewise the result of scarcity of ideas for individual action; though the col-

oring of the religious behavior, whether it be ecstasy or abasement or union with God, may perhaps be varied by emotional factors already present. Stereotypie is certainly a result of lack of new ideas. Symbolism is much like Biblical quotations in that it is the application of a borrowed means of description in place of making one's own articulate expression.

In this way all fantastic developments, even hallucinations and delusions, perhaps may be a result of the thought blocking. The latter is then the central feature of the whole picture and the one which we wish to study further.

This blocking of thought we regard as a profound confusion, a very extensive inhibition, analagous to the milder inhibitions such as "stage fright," lapses of memory, or repressions giving rise to the presence of delusions.

The development of this blocking is the result of millions of experiences dating possibly from the patient's birth.

A little more fully stated the thesis is that the human mind, subconscious and conscious taken together, at infancy is like a very sensitive plant. An unsympathetic environment which does not constantly encourage its growth, and more, an outspokenly aggressive environment, acts on this sensitive plant causing many painful experiences and memories. These in turn inhibit the growth of the delicate tendril-like processes of the mind and distort the final growth of the individual. Or expressed differently, the mind of the person is inhibited.

Thus as people grow up we get all grades of inhibition from the "normal" person whose artistic capacities and means of self-expression are hopelessly tied up, through the more inhibited types, the shy, the diffident, the person who is too inhibited to carry on the average life, to the still more inhibited. Now as the inhibition reaches an overwhelming degree we say the patient has Dementia Precox and the actions resulting from his inhibited mental processes we call the symptoms of the disease. There are mild types of the disorder, "simple deterioration," and a gradation all the way to the very serious dissociation of mental processes or deterioration which rapidly ends in death.

Let us illustrate by still further detail.

THE SITUATION.

Reducing the question to its simplest terms, it seems that when we analyze each of the various reaction complexes grouped under the caption of Dementia Precox or Schizophrenia, we come upon essentially the same underlying human drama.

First we find that the individual has always been somewhat different from his fellows. He has belonged to the "shut in" type described by Jung. Instead of playing in the carefree, boisterous way of many children, he has been shy and retiring, abhorring strife, very sensitive

to perhaps music and colors and the beauties of nature, all of those things which we find in adult life to be the stimulus to the artist. Being different from his acquaintances, he has but few confidants, possibly he has one, but here the friendship may be very intense. Abhorring strife and the competition of children's groups, he keeps much alone; in fact, he feels most at ease when alone. It is a question if he is properly called the "shut in" type. He might perhaps be better described as being "driven in" on himself—an introverted personality. This may all be covered by an assumed shell of outer hardness, but is apparent in varying degrees.

Many of these young people are intuitively altruistic and over-conscientious and responsible. They may carry the burdens of the world upon their young shoulders, they may be filled with schemes to improve life for many people, world improvement schemes, profundities to which most people have grown callous with time. They are often the over-sensitive, the over-gentle, the super-kind.

One gains the impression with many cases of Dementia Precox that there are countless unexpressed desires and impulses which are groping blindly for a way of expression, but never find it. In fact, the very inarticulateness is one of the most striking characteristics of Dementia Precox.

As a *second* factor in the development of Dementia Precox, we have this sensitive, gentle, inarticulate person meeting an environment which to him means death itself, death to the growth of *new* ideas, unusual hopes, "long, long thoughts," which we know are characteristics of youth and childhood.

COURSE

To begin with, the play of children and their treatment of each other is characterized by keen, struggling, almost cruel competition. The domination of one child by another, the hostile criticism and teasing of one child by one or all the others, brings the greatest pain to this quiet, gentle type.

Then schools are manifestations of competition, the upper classes against the lower, the older boys against the younger, the strong against the weak. It must be confessed also that where all should be tolerance and patience and encouragement, i. e., at the hands of the teachers, there is often arbitrary treatment. This has been well described:

"It seems to me that in our present mechanical, unimaginative routine of 'instruction' based upon exclusive objective ideals, we have an example of what may be called the 'institutional neurosis.' The genus 'school ma'am,' conjuring visions of an austere, puritanical female, policing formal rows of intimidated children, affords us a familiar clinical symptom of this institutional form of repression. In the typical preceptor with his overzealous emphasis upon stricture and discipline, the psychoanalyst suspects that the real motive is some secret discomfiture—some hidden discrepancy in the life of the teacher himself. And,

in reality, upon analysis, we find within him an overweaning desire to assert his own will, to coerce, to restrict, to repress the spontaneity of others. His libido has been deflected from its primary, affectional sphere, to a regressive, sadistic plane. Following the introversion attendant upon his own disappointment, the contemplation of childhood fills him with bitterness and pain, and in truth the motive that draws such an individual to the career of teaching is, only too often, an unconscious resentment."*

So that this child feels himself overlaid by layer upon layer of more or less hostile people, older than himself in years, and stronger in the power to hurt and make life miserable for him.

From within, too, come further disturbing factors which conflict with what he has been taught.

It is perhaps not exaggerating to state that only in the exceptional case a child has his questions answered and is told freely and frankly and wholly about many things. But especially rarely is he told about sex and all its manifold and far-reaching radiations. Rather the attempt is made to brush any knowledge or ideas of sex completely out of his consciousness and out of his world. He is taught that he should not think of it, much less know of it, and that there is something shameful connected with the whole subject. It is a subject on which there should be no thought. And yet every child has some glimmering of sex consciousness, some vague curiosity concerning sex and creation, which seem incontrovertible, natural, and not only right, but beautiful.

Again, perhaps the strongest influence of all, come the child's parents. Many people see sometimes that the child seems hostile to his parents, but often what is more truly the case is not seen, namely, that parents are hostile at times to their children. This may be conscious but it often is not. Now, that this statement may not seem quite unfounded, we might quote the familiar observation that a mother wishes to keep her children as infants, "tied to her apron strings," and is jealous of their becoming interested in other women.

Now this would scarcely seem hostility on the part of the mother, until the child or youth no longer wishes to remain an infant "tied to the mother's apron strings" and then the hostility appears. By having his ambitions opposed (though perhaps not frankly so), hopes quashed, and desires for liberty curtailed, he feels about him an iron wall against his growth. His attachment for her also renders her power over him all the more absolute. But this also he has been taught to deny.

The father-son rivalry means no less an equal form of opposition to the child. Though this may come to almost open warfare as the youth begins to mature, in early childhood, and with this "shut in" personality, it exists chiefly in the form of domination of the father over the child. We have all observed those sires who demand "immediate obedience," who stress the patriarchal (and prehistoric) idea of

*Dr. Trigant Burrow: "Permutations Within the Sphere of Consciousness." Jour. Abn. Psych. Aug.-Sept. 1916.

the duty of the child to his parents, ignoring of course the duty of parents to their children; and we have perhaps deplored many times the lot of those children who must give in to them in many unnecessary acts of discipline and almost slavery.

But perhaps the less obvious and for this reason the more deadly are those fathers who do not oppose their children openly (for then such children often develop into open rebellion and thence freedom), but do so in less apparent ways. Viz., when creative desires are derided, and those very sensitive subjects, early creative attempts, are made light of, treated as childish vagaries instead of the development of personality, or treated with cold, absolute indifference.

Or parents may have their conventional ideas as to what people should be, and try to compress these growing spirits to fit, to make a bush into a fence post, a Pegasus into a cart horse.

The minds and interests and possibilities of children are so little understood by their elders and the children are so often discouraged by the obstacles set before them, composed of the lack of understanding of their elders, that by the time the children reach adolescence, all spontaneity and originality has been pressed out of their consciousness. It is fair to state that of all children, the majority are prevented by their parents from developing to their greatest capacity. It is a very rare thing that an interest in a child is strong enough to overcome the opposition thus set up by the parents.

As Dr. Meyer puts it:

"The greatest difficulty in life, the greatest source of disharmony, (apart from the influences of heredity, infectious disease, and poor feeding, and poor chances for growth,) is the discrepancy between impulse, yearning and ambition on the one hand and the actual opportunities and actual efficiency of performance on the other."

The child, no doubt, seldom formulates this in his mind. The greatest tragedy is that the situation does not get to his consciousness. He is just disturbed without knowing why. Conscious wants may be agonizing, particularly when active. As an artistic friend once wrote: "To want to do, and to remain passive; to want to express, and to remain mute. This is perhaps the keenest suffering."

And yet here the want is at least conscious; we know what it is we want. But there are still deeper wants of which we are not conscious; when we want for something and do not know what it is. This latter kind of want is the most disturbing as it is the least definite. Its very uncertainty adds bulk and distress.

The inarticulateness of the whole situation of Dementia Precox, the vagueness of the factors, the fact that much of it goes on below the level of the patient's clear consciousness, shows the deplorable state of a present day education which grants such a small degree of consciousness to those within its domain.

Now the child is very largely the resultant of the compression put upon him by his environment, for his spirit is young, and tender, and plastic, and he is just one alone; whereas his environment is old, and set, and adamantine, and infinite. If a young plant be prevented from growing in one direction by a stone set beside it, it can grow but in three directions; if it have a stone on two sides of it it can grow but in two directions and upwards. But if a great stone be set on top of it, it will grow greatly distorted, or it will not grow at all.

And so it is with the spirit of children. They present all gradations of impaired development. Some personalities hit off a compromise between what they desire and what is desired of them, and become the usual ordinary, much inhibited, unoriginal person; others become hard and fight their way through to liberty, but they always carry scars of this fight with them thereafter, and even pieces of their hardness like bits of armor, which often surprise us years later by suddenly appearing in unexpected places. Now the individual variation among various young spirits here enters; the reaction is not alone due to the impress of the environment, but the constitutional make-up of the person determines to a certain extent also the result. The "shut in" or more properly "driven in" or the pre-Dementia Precox type is too gentle, too kindly to fight. The stone placed upon him is too great. His spirit cannot push it aside, and being thus pressed upon, it can only grow distorted.

At adolescence, the child is overwhelmed by a surge of feelings and desires and vague longings, which bring varying amounts of shamefulness according to his training and which, strive as he might he finds himself unable to drive from his consciousness.

Though this is the period of budding forces he does not know what he is interested in, what are hence his fortes, what line to follow. He wants to do growing, budding, increasing things. Having been forced for years outwardly to conform, he finally is unable to do otherwise. But only outwardly. The universal spirit within, full of spontaneity, interests, far-reaching visions, will not and cannot be denied. His spirit is too new, too soft and bud-like as yet to fight its way out to a clear view of the situation. In many ways he will be much attached to his parents, and there will be great conflicts in him between wishing to be as they mould him, to think as they direct, to try to deny those ideas upon which they have placed the sign "forbidden," and his inward conviction of what is true and therefore right, the path which his spirit points out for him to follow. In fact, it is this very morality, this wish to obey those parents, as opposed to what his sense of truth and justice tells him, that causes the confusion; that is what Burrow means when he says that it is *"an organic morality"* that forms the basis of the mental disorder.

RESULT.

Life, real life, mental life, is composed of stimuli—inspirations, thoughts, ideas—received and transmitted into acts. When these thoughts, too great for expression or even consciousness, struggle for expression and action, and this action is prevented, we get a distortion of the spirit and of the personality. This disorder of all the impelling and expressive factors of the personality in the extreme case are what become known to us as the symptoms of Dementia Precox.

THE CHANGE.

The change in the individual becomes at last obvious, and there is present an interference with the course of normal thought action, an inability to do the usual work, to think clearly. In an intelligent intuitive person it is felt as a definite "block in thought"—a certain something stops his flow of mental images and means of expression. A less intelligent person may adduce reasons of his own for his behavior—he may "reason as he does." Owing to the automatic nature of behavior these factitious reasons must be separated off from the picture.

A still less intelligent person projects it on to persons around him and asserts that a "spell is put upon him," "he is hypnotized," "electricity is sent through him," etc. This may take place very rapidly with marked excitement and appearance of fear, as if the change, though but dimly sensed, had frightened the person. This may often be the basis of the Dementia Precox excitement and violence.

The catatonic has reacted to this feeling of sudden deterioration by trying to fight it, the muscular tension and active resistance being merely an evidence of the inward opposition to this unaccountable loss of capacity. Excitement and violence may also be a sign of opposition to this overwhelming change.

One type of person mentally puts himself back in his mother's womb to gain comfort that way and be new born; to be "born again" in order to return refreshed from this inability to think.

Another runs to religion and belief in God in just the same way—(something stronger, all powerful, an ever-present help in time of trouble). Christ may be the Mother image, and being Christ is being the mother or being with her. For lack of ability to formulate and express his puzzlement, he idly places symbol after symbol in a line across the page.

All, in short, are seen to show more or less distinctly a feeling of sudden loss of capacity, the individual reaction to this differentiating the different types. The patient is completely overwhelmed by the storm arising within his subconsciousness. The inward conflict between the desires he feels to be present and the teachings of his environment to the contrary, i. e., the social repression, between his diffident hopes and memories of harsh experiences in attempting to real-

ize them, causes his attention to be turned from the outside world in upon himself; his attention becomes introverted. He turns from a world which is practical, unsympathetic, painful, into the world of his own thoughts where no discordant criticism is raised, no dreams forbidden.

His attention being little in the world about him, his behavior towards it becomes purposeless, haphazard, and casual. He reverts to the easiest adaptation to it or form of behavior he has memory of, infantile or almost automatic action; perhaps he reverts even to the prenatal form of behavior, wherein he is nourished, warmed and clothed, all with no movement or effort on his part. Thus we see why he keeps to himself, why he wants to be let alone, to live in revery, to cease from every form of activity. At last in the aberrant reactions of Dementia Precox he has found a long sought and eternal peace.

Truly did the old Greeks say, "Those whom the Gods love (i. e., the kindly, the gentle, the loyal) die young."

Thus we see that in some cases the so-called Dementia Precox is, like the neuroses, a disorder which arises in a certain type of person as a result of a certain type of treatment accorded him by the individuals forming his environment. Why the individual is so constructed, and why others should treat him in this way are questions only to be treated of in more advanced works.

A theory that shows us how inhibited states develop puts us one step on the road toward preventing them; and holds out the hope to everyone thereafter of a more full, more active, and more conscious life.

A few of the factors concerned in the causation of the disorder are here touched upon; perhaps the future will bring to light many more.

II. The Neuroses or "Nervousness" of Apparently Well People.

These states are quite different from any of the foregoing. For the most part, they are not apparent to anyone but the patient or to those who know the patient well. The patient can usually carry on his work after a fashion and physically looks well enough, he sleeps well, has a good appetite, and has the appearance of health, and a detailed medical examination fails to reveal any physical basis for the condition.

He himself, however, feels that he is radically prevented from doing his work or acting or thinking with the ease that he may previously have enjoyed. He may feel that he gets fatigued after a very short time, and then feels "done up" for the rest of the day, or he is troubled by vague feelings of impending disaster, or is obsessed by the feeling that he must viz., count every white automobile that he sees. The various symptoms have been grouped together and the various symptom complexes designated as follows:

1. NEURASTHENIA.

The term, which means literally "nerve weakness," is applied to bodily conditions which seem characterized by irritable debility. The patient is easily fatigued. He or she has a constant backache or headache, and very little physical or mental activity is sufficient to increase these aches to the point that they force him to stop and rest, or lie down. Abnormal sensations are felt, or the reactions that normally do not come to consciousness are perceived.

He may have a pain which moves about in the abdomen and travels up to the heart, or to various places in the chest or back. The normal peristaltic movement of his bowels may be felt by him to his constant worry. Irregular pains, backaches, headaches, burning in the abdomen, fatiguability; symptom groups much like some of the thyroid states are characteristic, hence the thyroid must be carefully investigated.

2. PSYCHASTHENIA (psychic weakness) used for conditions of

(a) Obsessive or compulsory thinking *(obsessions)* such as a feeling of compulsion to count the numbers of houses when passing in a car, a feeling that a certain thing is so when our better judgment tells us it is not, etc. A man may feel that he has killed his brother though he may know him to be alive, etc.

(b) Fear of some special situation or object (*phobia*). Fear of open spaces, (agarophobia), fear of being in a closed room (claustraphobia), fear of dirt (mysophobia). In the following we see a phobia and an obsession:

A young woman of 19 had been married for a year to a young man of 21. In all that time there had been no sexual intercourse as the patient had been afraid.

For six months the patient had been very fearful of contamination and solicitous of washing her hands; she would wash them every few minutes. If she saw a blind man, especially, she would turn right around on the street, hurry home, and wash her hands. She had washed her hands so frequently, and with such a strong disinfecting solution (sulpho-naphthol) that they were excoriated for large areas.

3. HYSTERIA, a very suggestible state in which some intense idea or emotion seems to result in an impairment of some part of the body, such as hysterical paralysis of arm or leg, hysterical blindness, deafness, etc. These can be readily detected by medical tests as the necessary structures are still intact.

Hysterical convulsions also may be the result; and the basis of many cases of epilepsy may be hysterical.

4. ANXIETY NEUROSIS *or Anxiety Status.*

Many cases of Neurasthenia are really cases of Anxiety Status. The two merge imperceptibly and in short arise virtually on the same basis and are the same disorder. The characteristics of Anxiety Neurosis

are feeling of apprehension, fear of some vague impending disaster; perhaps anxiety attacks with rapid heart, breathlessness, weakness; worrying, inability to do one's best work.

Patient, a young man born in a small town in Virginia. As a boy always shy, diffident, and seclusive, disliking rough games and vigorous sports. Military school 15-16, but here very much alone and lacking confidants. After a few months' business course he went away from home to work in a strange town. Here he lived in the apartment of some friends who were away.

Suddenly one night he had a heart attack—heart beat very fast and forcibly, and he thought he was going to die. For two weeks he had several attacks, always accompanied by fear. This was erroneously treated with Digitalis by a local physician. After a month of this he began to fear leaving his house or yard, and was afraid to attempt going anywhere for fear of another attack.

Finally he took an easy job in a local bank where pistols were kept. Then suddenly he began to think, "What if I should kill myself!" Four months after the original attack he began to have periods of depression in which he would cry.

On entrance he was co-operative though slightly ill-at-ease or anxious. He expressed himself as being nervous and at times depressed and afraid to do anything out of the ordinary—afraid of going out and among people, under constant fear of killing himself, so that at the sight of a razor or knife or sharp article in a store, or on crossing a bridge he would think of suicide and fear he might end his life.

Physically he was well; his heart especially was normal in every way.

Course and development: Through free associations and analysis of his dream material, his diffidence and fear of being with people were traced to a masturbation complex and unrecognized homogenic impulses. Mother fixation also played an important part. A gradual assimilation of these resulted in such improvement that he secured himself a position and advanced himself from this position to a better one. The depression disappeared, and the ideas of suicide retired to the role of mere fancies.

DISCUSSION OF CAUSES OF NEUROSES.

Though it is, of course, not known what may be the future discoveries in the domain of the emotional disturbances, nevertheless the more recent psycho-analytic investigations have already shown us some very interesting facts. In all the neuroses the real trouble is not that of which the patient complains, or which exhibits itself as perhaps the major feature. The difficulty is in reality at the antipodes, so to speak, of the patient's personality. It lies not in a bodily ache, but in a mental conflict. The bodily complaint or hysterical attack is "played up" automatically by the patient merely to take his attention from the greater trouble, the mental conflict.

Bernard Hart's little book, *The Psychology of Insanity*, depicts in a most engaging manner the common habit of avoidance of unpleasant thoughts or unpleasant constellations of ideas. These unpleasant constellations usually represent mental conflicts; one part of us wants one thing, another part the other. The struggle between the two becomes so painful that rather than step in and take the extra pain of settling it, we avoid the whole subject altogether and try to forget it. Through a clear and simple explanation there is shown how this conflict and evasion causes the changes in the individual's personality known as

the various symptoms of the disorder. The so-called symptoms may really be a protest of the patient's subconscious against the life he is leading at the time.

Let us quote directly from another author the following:

"Whether it is a question of the vicarious impulses and imperatives belonging to the obsessional state; or of the characteristic somatic alternatives of hysteria; or of the mitigating substitutions and replacements constitutive of paranoid mechanism, or of the organic equivocations of the anxiety dissociations; or of the exaggerated mood reactions presented in the temperamental subterfuge of cyclothymia, or of those manifold metabolic mimicries grouped under the ample category designated by the popular misnomer of "neurasthenia"—under whatever alias the organism may seek to elude the demand most vital to it, at the heart of the neurosis the essential situation is a moral revulsion.

"This revulsion is directed unfailingly against the admission of primary, egoistic, organic, unconscious sexual trends.

"The essential moral situation present in the neuroses, the inherent conflict of good and ill, is then the dominant picture in these disorders."*

In *obsessions*, that is, in the states in which the patient feels compelled to do or to think certain things against his will, as it were, he takes refuges in these compulsive acts and thoughts from the painful conflict of ideas. Viz., by counting the numbers on every house he passes, the patient avoids thinking whether he should replan his whole life work, etc. In *hysteria* the mental conflict is converted into a bodily change, viz., the action of an arm may be temporarily suspended and we have what we call hysterical paralysis; or the action of the eyes is held off, and we call it hysterical blindness; of the ears, it being hysterical deafness, etc. In this way the patient's subconscious attracts his attention to these symptoms and away from his conflict. In the *paranoid* states the patient puts his attention into self-love, self-admiration (self-exaltation) and thus takes his attention from trying to improve himself so as to gain the good graces of others. He says to himself they are inferior, they fear him and hence plot against him. Or, and he will not admit this to himself, his fear is born of desire and he unwittingly loves them to such an extent that this repressed desire makes him afraid of them.

In *anxiety conditions* the patient emphasises fears and apprehensions to get away from his greater difficulties; so also in *cyclothymia* or the mild *elated-depressed* reaction, the exaltation causes the patient to think of outside objects rather than his inner thoughts.

The *neurasthenic* hides his conflicts in exaggerating his various normal bodily sensations into symptoms. Things which most people pass by as being all in the day's course of events he magnifies to Gargantuan proportions so that he need not think of his complexes or mental conflicts.

TREATMENT

The treatment of all those mental disorders listed under Section A, that is those associated with cortical changes and general medical dis-

*Dr. Trigant Burrow. "Character and the Neuroses."

cases, falls within the domain of internal medicine and can be studied there in detail. In the main the principles are elimination of toxine, conservation of the vitality and, in some cases, specific medicines to cure the disease. It is best carried out in a psychiatric clinic which is a unit of a general hospital, with the most favorable conditions of quietness, kindly nursing, medical and psychiatric care.

The treatment of the outspoken psychoses of Section B—those without underlying medical disease, necessitates in many cases the facilities of a hospital. The acute period of disturbance ideally treated should be carried out with the patient fully isolated from the sight or sound of other disturbed patients, and there should be an abundance of intelligent and kindly nursing and medical attendance.

The expense of all this, however, precludes such conditions for most people so that treatment of the majority of cases is carried out in institutions with varying numbers of patients to a ward. Here again the keynote of treatment, in the acute stages particularly, should be kindliness so that the patient may come through his illness as quickly as possible, and have only his own internal difficulties to contend with, these being quite enough without anything from the outside being superimposed. Too many of our institutions, unfortunately, are run on a basis of penology, rather than psycho-pathology; that is, the patient is punished in various ways, including physical violence (sub rosa, of course), for his uncompromising behavor. It is unthinkable to expect a set of ignorant, poorly paid attendants to take an intelligent view of such a complicated mental reaction as insanity. The introduction of trained nurses and better salaries and hours has been of value in this. Perhaps these conditions are due to the universal avoidance by the public of all ideas dealing with mental disorder, based, it may be, on lack of knowledge of the subject.

After the disturbance has somewhat quieted down, occupation is of great benefit particularly the more primitive and fundamental hand work such as the manual labor and interest of raising a garden, the gathering and cutting of wood for one's own fire, the making of various articles of wood or other more artistic activities. As mentioned in the discussion of Dementia Precox, many such elementary and artistic impulses are lying latent for want of opportunity in psychiatric cases. In the abundance of time afforded in most cases, means of artistic expression may be developed through which the patient may maintain his equilibrium during the rest of his life. In all cases the environment should radiate normality and health and hope. The patient who is recovering from a disturbance is often in a particularly sensitive state wherein a quiet environment with much outdoors has greatly to do with aiding final recovery.

Finally there should be a thorough sifting of the facts of the illness as complete as the patient has intuition for. He should clarify

his ideas concerning his family, his relationship to each member of it, the factors of his own makeup, his predilections and capacities, his opportunities and activities. A further analysis should be made whenever possible as to the emotional state underlying his disorder, and the specific causes in himself of this actuating emotional state.

REST CURES.

Rest cures, after the manner of Weir Mitchell, do not now enjoy the same praise that they did when first introduced a generation ago. Foremost authorities now consider that their indiscriminate use in those many mild cases of emotional maladjustment or disorder, called "nervous breakdown," or "nervousness" can be supplanted with a more constructive form of treatment.

If the psychotic situation is considered to have come about because of the effect of the environment's acting on a certain type of individual, then a rest from this environment might be urged to have certain advantages. But to return the patient at the end of the period into the same environment, without making any radical change in the environment, is merely setting the clock back a few days. The same result will inevitably take place again.

And, moreover, to consider again the action of the environment on the person; some permanent effect or record has been made on the patient by this environment. The patient does not return to normal by merely removing the environment. By no means. Every form of matter has a very definite property of memory or ability to retain impressions or records made upon it, and most especially the human nervous system, not to speak of those subtler entities, the emotional makeup or personality.

One might argue that, since life consists of stimuli received transmitted into acts performed, a cutting off of the stimuli reduces the action, and hence the wear and tear on the organism. But this is not possible; one cannot cut off all stimuli. We receive many stimuli from our surroundings, especially so from the wards of a hospital or sanitarium. And apart from these, our memory itself, as mentioned above, not to mention our ideals, would supply us with stimuli for a longer time than ever was contemplated for a rest cure. And to deny an outlet to these stimuli has a disturbing and destructive effect on the organism.

These patients suffer already from too little life; from the fact that they cannot convey their many stimuli into actions. They are already confused or disturbed. This is the meaning of maladjustment.

Now, if instead of letting the patient lie idle in a virtual imprisonment, the time were taken up with an intelligent and painstaking analysis of the whole situation, with a study of the underlying factors and the makeup of the individual himself, the patient would be sent back

into the damaging environment a new and different person. But this is rarely done. Only the most superficial statements are made to the patient.

To remove the stimuli completely, as the rest cure sets as its goal, would be to reduce the patient to a state of such vegetable existence as society shudders to place as the worst punishment upon its most horrible criminals. It means, at the least, mental annihilation for the period of the "cure." The patient then has to recover as best he may from this annihilation. Failing in this, and happily the cure does in many cases, it means that just so much time is thrown away out of the patient's life. For here is the point: Constructive work, and only constructive work, will change either the environment or the person, and hence the situation.

For the neuroses and milder managable psychoses already established or about to be, Psycho-analysis, for those who are accessible, is the remedy par excellence, and the only real remedy.

Where a patient has the least speck of intelligence, electrical treatment for the neuroses or dilation of the rectum for hysterical attacks belong to the same archaic stage of medical superstition as the burning of witches, or employing amber beads or horse chestnuts to prevent arthritis.

Psycho-analysis is a setting straight of mental disorder, by tracing back our thoughts to the deeper motives from which they have sprung and thus getting at what really does actuate us.

The best way to do this is through the utilization of associative material, preferably that of dreams, by taking each element of a dream and tracing all of the associations in our mind until the thought for which this stands in symbolic form is found. Every dream, then, is found to contain a hidden wish which for some reason or other we would not admit into the full recognition—the lime-light—of our attention.

Eventually one arrives at the emotions and instincts underlying our behavior. This means long and painstaking work, for it deals with the subtlest yet most enduring of material, namely, the personality; and the slightest gain means an advance of the whole person into greater development, a new life.

MEANS OF PREVENTION

For those psychoses of organic origin, the means of prevention consist almost completely of those which enter into general medicine, including hygiene, early treatment, moderate habits, life more in accordance with the demands of our structure, free exercise and outdoor play.

For those associated with industrial diseases there remains as the only remedy the general country-wide elimination of those dangers from trades.

As to the psychogenic disorders, or disorders of emotion, they are as indicated in the discussion of Dementia Precox, of social origin; that is, the lack of consciousness of underlying motives and emotions and instincts on the part of society as a whole results in such treatment of those who are quasi-conscious of these underlying forces that the latter take refuge, in an abortive or compromise expression of what they feel; the abortive expression or compromise being known as the mental disorder.

As general consciousness of these facts grows in society, mental disorders of this type will diminish in the individual.

Specifically, a much freer, more individual, more personal, more interesting form of education in the family and in the school, of the parents and of the children, allows a completer, truer, sounder, clearer mental development of those who follow.

REFERENCES

Dr. Adolf Meyer—*Notes of Clinics in Psycho-pathology.*

Dr. Bernard Hart—*The Psychology of Insanity.*

Fundamental Conceptions of Dementia Praecox. British Medical Journal, Sept. 29, 1906.

Dr. Trigant Burrow—*The Psychanalyst and the Community.*—J. A. M. A., June 13, 1914, Vol. LXII, pp. 1876-8.

The Meaning of Psychoanalysis.—Jour. Abn. Psych., April-May, 1917.

The Origin of the Incest Awe.—Psychoanalytic Review, July, 1918, Vol. V, No. 3.

Rabindranath Tagore—*My School.*—In the Group of Essays Entitled "Personality."